STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155029	A. BUILDING 01 B. WING	05/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY NURSING AND REHABILITATION CENTER	5600 EAST 16TH STREET INDIANAPOLIS, IN46218

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 05/02/11 Facility Number: 000012 Provider Number: 155029 AIM Number: 100274900 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Community Nursing and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two story facility was determined to be of Type II (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and all resident sleeping rooms. The facility	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	has a capacity of 115 and had a census of 107 at the time of this visit. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 05/06/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0021 SS=E	Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 Based on observation and interview, the facility failed to ensure the kitchen 1 of 1 rolling fire doors in the opening between the kitchen and the first floor Main Dining room is held open only by a device arranged to automatically close upon activation of the fire alarm system. This deficient practice could affect all	K0021	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The entry door to the main dining room has a positive latching mechanism in order for the door set to latch to the frame. **How will you identify other**	05/27/2011

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	residents, staff and visitors in the vicinity of the first floor Main Dining room. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 11:30 a.m. to 1:00 p.m. on 05/02/11, the kitchen adjoins the first floor Main Dining room and a serving window from the adjoining kitchen has a rolling fire door equipped with a fusible link. The serving window rolling fire door does not close upon activation of the fire alarm system. The Main Dining room was not separated from the corridor because the entry door set lacked a positive latching mechanism for the doors and the door set did not latch into the frame. Based on interview at the time of observation, the Maintenance Director acknowledged the first floor Main Dining room entry door set was not provided with positive latching hardware and the rolling fire door does not close automatically upon activation of the fire alarm system. 3.1-19(b)		**residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Maintenance Director has been in-serviced on assuring that all doors acting as a barrier between a room and a corridor must separate the two (2) by having a positive latching mechanism to the door frame. Director of Maintenance or designee will make rounds weekly x 4 and then monthly thereafter to ensure all exit components latch to the doorframe. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The CQI committee will review the results of the exit component rounds conducted by the Director of Maintenance/designee for compliance. If compliance is not achieved, an action plan will be developed to ensure compliance.	

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K0025 SS=E	Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure openings through 1 of 2 smoke barriers on the second floor were maintained to provide the minimum 1/2 hour smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect residents, staff and visitors in the vicinity of the smoke barrier doors by Room 216 if smoke from a fire were to infiltrate the protective barrier. Findings include: Based on observation with the Maintenance Director during a tour of the	K0025	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The twelve (12) inch square opening in the smoke barrier wall set by room 216 is fire stopped to ensure that the opening is not exposed. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Maintenance staff was in-serviced on assuring any openings through smoke barriers must be maintained to provide ½ hour smoke residence. Maintenance Director will make rounds to check all smoke barriers weekly x 4 and then	05/27/2011

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	facility from 11:30 a.m. to 1:00 p.m. on 05/02/11, the smoke barrier wall above the smoke barrier door set by Room 216 had one, twelve inch square opening in the smoke barrier wall which was not firestopped exposing the opening. Based on interview at the time of observation, the Maintenance Director acknowledged the twelve inch square opening in the smoke barrier wall above the ceiling at the smoke barrier door set by Room 216 is not firestopped which exposed the opening. 3.1-19(b)		monthly thereafter to ensure corridors are maintained. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The CQI committee will review the results of the smoke barriers for compliance. If compliance is not achieved, an action plan will be developed to ensure compliance.	
K0038 SS=E	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure the means of egress through 3 of 6 first floor delayed egress locks was readily accessible for residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, allows approved, listed, delayed egress locks to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6,	K0038	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The front entrance exit door, the main dining room exit door, and the West emergency personnel exit door will each release their locks within 15 seconds of application of force. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**	05/27/2011

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	or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (a) The doors unlock upon actuation of an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, or upon the actuation of any heat detector or not more than two smoke detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6. (b) The doors unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less that 1 inch high and at least 1/8 inch in stroke width		All residents have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Maintenance staff was in-serviced on assuring all doors equipped with delayed egress locks are readily accessible for residents, staff and visitors. Maintenance staff will test all doors equipped with delayed egress locks weekly x 4 and monthly thereafter to assure locks will release within fifteen 15 seconds of applying force. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The CQI committee will review the results of the egress locks conducted by the Director of Maintenance for compliance. If compliance is not achieved, an action plan will be developed to ensure compliance.	

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	on a contrasting background that reads: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect any resident, staff or visitor needing to exit the facility from the front entrance exit door, the main dining room exit door and the West emergency personnel exit door. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:30 a.m. to 1:00 p.m. on 05/02/11, the front entrance exit door, the main dining room exit door and the West emergency personnel exit door each have an adjacent sign stating "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". In addition, the front entrance exit door, the main dining room exit door and the West emergency personnel exit door each are equipped with delayed egress locks but each of these three exit doors would not release when the door handle was pushed for more than fifteen seconds. Based on interview at the time of observation, the Maintenance Director acknowledged each door should have released when pushed for fifteen seconds and acknowledged the front entrance exit door, the main dining room exit door and the West emergency			

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	personnel exit doors did not open when the door handle was pushed for more than fifteen seconds. 3.1-19(b)			
K0050 SS=F	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 1. Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on the third shift for 1 of 4 quarters. This deficient practice affects all occupants in the facility including residents, staff and visitors. Findings include: Based on review of "Monthly Fire Drill Report" documentation with the Maintenance Director from 9:45 a.m. to 11:30 a.m. on 05/02/11, there is no documentation of a fire drill being conducted on the third shift in the third quarter in 2010. Based on interview at the time of record review, the Maintenance	K0050	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** An in-service was conducted with the maintenance staff to ensure fire drills performed are unexpected and are at least conducted quarterly on each shift. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? Fire drill	05/27/2011

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	Director stated the third shift fire drill was conducted but acknowledged there is no documentation of the fire drill report available for review. 3.1-19(b) 2. Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions for 4 of 4 quarters. This deficient practice affects all occupants in the facility including residents, staff and visitors. Findings include: Based on review of "Monthly Fire Drill Report" documentation with the Maintenance Director from 9:45 a.m. to 11:30 a.m. on 05/02/11, second shift fire drills conducted on 06/16/10, 07/30/10 and 02/24/11 were each conducted at 3:05 p.m. and third shift fire drills conducted on 05/14/10, 10/15/10 and 03/11/11 were conducted, respectively, at 5:10 a.m., 5:10 a.m. and 5:00 a.m. Based on interview at the time of record review, the Maintenance Director acknowledged second and third shift fire drills were not conducted at unexpected times under varying conditions. 3.1-19(b)		schedule was developed to ensure fire drills conducted are at unexpected times and under varying conditions. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The CQI Committee will review the results of the fire drills for compliance. If compliance is not achieved, an action plan will be developed to ensure compliance.	

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K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on record review and interview, the facility failed to ensure a complete written record of weekly inspections of the starting batteries for the emergency generator was maintained for 1 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include:	K0144	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The emergency generator has been tested to ensure it turns on within ten (10) seconds of power outage. In-service was conducted with Maintenance staff to ensure the emergency generator is checked weekly. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Maintenance staff was in-serviced by the Executive Director on assuring that emergency generator turns on within ten (10) seconds of a power outage. Maintenance Director has in-serviced maintenance staff on how to check emergency generator in the absence of Maintenance Director. Maintenance	05/27/2011

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	Based on record review of "Emergency Generator - Weekly Inspection Checklist" documentation with the Maintenance Director from 9:45 a.m. to 11:30 a.m. on 05/02/11, weekly generator checklist documentation for the week of 04/12/11 stated "Vacation" with no other documentation. Based on interview at the time of record review, the Maintenance Director stated no storage battery check of the emergency generator was conducted the week of 04/12/11 because he was on vacation and acknowledged no weekly emergency generator documentation was available for the week of 04/12/11. 3.1-19(b) 2. Based on interview and record review, the facility failed to ensure emergency power would be transferred to the emergency generator within 10 seconds of building power loss for 2 of 12 months. NFPA 99, 3-4.1.1.8 states generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient		Director/designee will check emergency generator 1 x weekly to ensure it turns on within 10 seconds of power outage. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The CQI committee will review the results of the emergency generator tests. If compliance is not achieved, an action plan will be developed to ensure compliance.	

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	practice could affect all residents, staff and visitors. Findings include: Based on record review of "Emergency Generator - Weekly Exercise/Monthly Load Test Log" documentation with the Maintenance Director from 9:45 a.m. to 11:30 a.m. on 05/02/11, monthly load test documentation for 01/04/11 lists the transfer time as 4.0 minutes and monthly load test documentation for 02/01/11 lists the transfer time as 8:50. Based on interview at the time of record review, the Maintenance Director stated when the emergency generator is in test mode it takes three to four minutes to transfer power to the emergency generator but in the event of loss of power to the building, it takes less than ten seconds to transfer power to the emergency generator. The Maintenance Director acknowledged monthly load test documentation for 01/04/11 and 02/01/11 did not state the transfer time was less than 10 seconds. 3.1-19(b)			